DOCUMENT RESUME

ED 176 144 CG 013 745

AUTHOR Lopez, Martita A.
TITLE Recognizing Nonverbal Cues of Emotion: A Training Program for Mental Health Workers.
PUB DATE 79
NOTE 8p.; Paper presented at the Annual Convention of the Southeastern Psychological Association (25th, New Orleans, Louisiana, March 28-31, 1979)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Affective Behavior; Communication Skills; *Emotional Response; *Mental Health; *Nonverbal Communication; Paraprofessional Personnel; *Psychiatric Hospitals; *Sensitivity Training; Visual Perception

ABSTRACT

An affective method is identified for increasing the sensitivity of paraprofessional psychiatric helpers to vocal (paralinguistic) expressions of the affect "sadness." Fifty-two male and female psychiatric hospital employees served as subjects and were divided into four groups, each of which was given identical pre- and post-testing. Group 2 received training on the vocal cues of sadness; Group 3 received vocal cue training and was exposed to slides of faces portraying various emotions; Group 4 was trained on facial as well as vocal cues of sadness; and Group 1 served as a control. Data analyses revealed that Groups 2 and 3 improved significantly more on the dependent measure of vocal sensitivity than Groups 1 and 4. In addition, both facial groups scored significantly higher than the control group and the vocal-training-only group on a generalization-of-training measure. Results suggest that Structured Learning Training can increase the sensitivity of paraprofessional helpers to vocal expressions of the affect "sadness," and indicate that including the facial mode during vocal training increases vocal sensitivity and generalization of training more than vocal training containing only the vocal mode. (Author/CKJ)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED176144

RECOGNIZING NONVERBAL CUES OF EMOTION:

A TRAINING PROGRAM FOR MENTAL HEALTH WORKERS

Martita A. Lopez, Ph.D.

Department of Psychology

Virginia Polytechnic Institute and State University

Blacksburg, VA 24061

Paper presented at

Southeastern Psychological Association, 1979

CG013745

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Martita A Lopez

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND THE ERIC SYSTEM CONTRACTORS."

In recent years, with the advent of the concept of the therapeutic milieu, the role of psychiatric nursing and attendant personnel has shifted from that of custodian to that of change agent (Cumming and Cumming, 1970). Krumboltz, for example (1967) has emphasized the necessity for the specific definition and validation of skills needed by these helpers. Empathy may be conceptualized as one such skill. Davitz (1964) defined empathy in terms of the perception and communication of emotion. It has been generally agreed that the effective therapist utilized his or her clients' nonverbal as well as verbal cues of emotion (Beier, 1966). However, despite the recent increase of studies on nonverbal communication, very little has been done to develop programs designed to help trainees become more adept at interpreting nonverbal cues (Harper, Wiens, and Matarazzo, 1978). The present study was concerned with developing an effective method to increase the sensitivity of mental health workers to vocal expressions of the affect "sadness". The present study was concerned with developing an effective method to increase the sensitivity of mental health workers to vocal expressions of the emotion "sadness". We began with this one emotion, with the idea that the complete program later on would include the other major emotions (anger, fear-anxiety, disgust, surprise, happiness) as well as blends.

The vocal mode was selected for training on the basis of findings reported by Mehrabian (1972) and his colleagues. In comparing different channels of nonverbal communication, these investigators found that the facial channel was weighted more heavily by subjects when decoding a communication than was the vocal, or paralinguistic, channel. In addition, Mehrahian reported that subjects were more accurate in decoding facial expressions than vocal expressions of emotion. These subjects lost potentially valuable information by being insensitive to vocal cues.

For our training program we decided to teach the vocal cues of sadness reported by Davitz (1964). He rated each emotion on six paralinguistic characteristics. There are loudness, inflection, pitch, rate, rhythm, and enunciation. For sadness the characteristics would be: a soft voice, a monotone going down at the ends of phrases and sentences, low pitch, slow rate, broken and irregular rhythm, and unclear and slurred enunciation in extreme sadness.

As a training method we used Structured Learning Therapy, a procedure developed by Goldstein which includes modeling, role playing, and social reinforcement, and also includes techniques designed to increase transfer of the training from the training setting to the real world (identical elements, stimulus variability, overlearning).

This study endeavored to provide preliminary answers to the following questions: (1) First, could the training of mental health workers increase their sensitivity to vocal cues of sadness? (2) Second, to increase vocal sensitivity in a realistic situation, is it necessary to include the facial mode of communication in addition to the vocal in the training? (3) Third, if including the facial mode in the training is necessary, to what extent should it be stressed?

Fifty-two psychiatric hospital employees including aides and Licensed Practical Nurses served as subjects. Half were women and half were men, and the average age was 36 with a range of 22-64 years. Three treatment groups and one no-treatment control group were employed, with 13 subjects randomly assigned to each group. The first treatment group received training in vocal cues of sadness only. The second treatment group received vocal cues training, and in addition was exposed to slides of facial expressions of emotion without being trained on specific facial cues. The third treatment group received training on facial as well as vocal cues of sadness. The no-treatment control group received no training. A male graduate student and the

experimenter were the trainers.

The following is a brief description of the training procedure. All three of the treatment groups received vocal cue training for sadness. We made an audiotape with five statements which were neutral in terms of content but expressed sadness paralinguistically using the cues we wanted to teach. The tape also contained 10 statements with cues of other emotions. The trainer began by discussing nonverbal cues of emotion and describing the vocal cues for sadness. These cues were projected onto a screen and this was left on throughout training. Next the trainer played a taped statement which expressed sadness and pointed out each cue. He replayed the statement to listen for each cue. This was the modeling component of the training method. Each subject, or trainee, then individually played a new statement and followed what the trainer had done, or, in other words, behavioral rehearsal. After everyone had rehearsed, subjects were asked to individually role play a person who was feeling sad and speaking. As each subject did this, the rest of the group listened for vocal cues of sadness and later discussed which cues had been present. Finally, the audiotaped statements were played again as subjects again individually listened for vocal cues of sadness. This time, however, subjects silently decided which cues were present and only said aloud whether the person was sad on not. As I mentioned, this training was given to all treatment subjects.

Group 2 received only this part of the training. Persons in Group 3 got exactly the same training except that, in addition, slides of faces portraying sadness or other emotions were paired with each statement on the audiotape. The emotion expressed by the face was not always congruent with that expressed by the voice. We did this to get closer to a more realistic situation.

In Group 4, subjects received the vocal cue training described above and, in addition, received facial cue training for sadness, using Ekman's description. (These cues, described by Ekman, include eyebrows drawn together with inner corners raised; wrinkles across the forehead with up-and-down wrinkles in the middle; eyes looking toward and/or glazed; eyelids drooping; and mouth open, with partially stretched, trembling lips; or closed, with outer corners pulled down.) Again, the facial emotion did not necessarily match the vocal emotion. Modeling and role playing included both vocal and facial cues for this group. The no-treatment control group, of course, received no training. The entire program lasted four hours for Group 2, five hours for Group 3, and seven hours for Group 4.

All subjects were pre- and posttested. Several dependent measures were utilized. The first was a measure of vocal sensitivity, which, in addition to audiotaped statements, presented facial slides; the combination of modes was used so that the measures would be more realistic than if only one mode had been included. This measure included statements used in training and new statements. Two other dependent measures assessed subjects' knowledge of the vocal and facial cues of sadness, respectively, from written descriptions. These were paper and pencil measures. The fourth dependent measure consisted of videotaped vignettes and assessed generalization of training to realistic situations commonly encountered in state institutions. Subjects were asked to judge whether or not persons in the videotape were vocally expressing sadness.

Split plot factorial and one-way analysis of variance designs were used to analyze the data. As predicted, the three treatment groups improved significantly more than the control group on the audiotaped measure of vocal sensitivity. Also as expected, the three treatment groups each scored significantly higher than controls on the paper and pencil test of knowledge

of vocal cues and only Group 4, which received facial cue training, scored higher than control subjects on the knowledge of facial cues measure. Finally, the two groups in which the facial mode was included during training scored significantly higher than the two non-facial groups on the dependent measure of generalization of training. The two facial training groups did not differ significantly from each other on this measure.

These data indicated that training mental health workers increased their sensitivity to the affect "sadness" expressed in the vocal channel. In addition, it was found that including the facial mode in training facilitated generalization of training to a more realistic situation. Simply including the facial mode in training was sufficient to produce this effect; training in the interpretation of facial cues was not necessary.

The results of this study suggest that mental health workers and others in the "helping" professions could benefit from a full-scale program of nonverbal cue training which includes each of the basic emotions. The program should emphasize pairing vocal cues with other nonverbal cues that occur in the natural environment. While this study found that including facial cues enhanced transfer, it may be that including other nonverbal modes, such as posture, would further facilitate transfer. Given the lack of transfer found in most training studies, this should be a major concern for all program developers.

SEQUENCE OF PROCEDURE

Pretests

Affect Recognition Test (audiotaped statements with neutral content)

Knowledge of Cues Questionnaire: Vocal and Facial (paper & pencil measure)

Training (Structured Learning Therapy)

Experimenter lists and explains cues.
Subjects model experimenter and overtly rehearse cues individually.
Subjects individually role play a person feeling sad or not-sad, while others watch for and describe cues.
Subjects model experimenter and covertly rehearse cues individually.

Posttests

Affect Recognition Test (audiotape)

Knowledge of Cues Questionnaire: Vocal and Facial (paper & pencil)

Videotaped Vignettes Test (videotape presentations of typical hospital situations to be rated for vocal cues)

1	2	3	4
No Treatment Control	Vocal Cues Training Only	Vocal Cues Training and Facial Slide Presentation	Vocal Cues Training and Facial Cues Training